British Health Ways 4

Supplemental Health Insurance

Information Notice

This contract was developed and negotiated for **SOFICA'S** with its registered office located at 6 rue Jean-Croix Treyeran - 33200 BORDEAUX
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Orias No.: 07031119 (www.orias.fr) - Insurance Brokerage Company, Siret No.: 379 683 550 00022

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Insurance agent and Management Centre: ASAF & AFPS

BRITISH HEALTH WAYS 4

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INTRODUCTION

The contract **BRITISH HEALTH WAYS 4** is an optional group insurance contract subscribed by ASAF & AFPS, hereafter referred to as the "Association," registered at : Les Templiers - 950 Route des Colles - 06410 BIOT, with AXA France Vie - a Limited Liability Company with a share capital of 487,725,073.50 euros - 310 499 959 Registry of Trade and Companies of NANTERRE - a company governed by the Insurance Code, with its registered office located at: 313 Terrasses de l'Arche - 92727 NANTERRE CEDEX, hereafter referred to as the "Insurer."

This contract was developed and negotiated for Sofica's with its registered office located at 4 rue Francis Martin - 33000 BORDEAUX, Orias No.: 07031119, Siret No.: 379 683 550 00022,

The Adherent joins the Association and benefits from this contract by means of the "request for adherence" under the conditions described in this information notice. The declarations made by the Adherents serve as the basis for their adherence, which may not be challenged once it enters into effect.

The Association shall provide for the management acts relating to the contract and the adherence. The Association may delegate all or part of these tasks to an organisation of its choice (following the prior consent of the Insurer). The Insurer insures the risks under this contract.

The contract between the Association and the Insurer is automatically renewed on the 1st of January of each year, unless it is cancelled by one of the parties by means of advance notice of six months provided by registered mail. In the event of termination of the contract, the Insurer undertakes not to terminate the guarantees granted individually to the Insured Persons, in accordance with article L.141-6 of the Insurance Code.

The contract may be modified by amendment. The Adherent will be informed by the Association of any changes to his/her rights or obligations, in accordance with article L. 1414 of the Insurance Code.

The contract is prepared and concluded in French.

The authority responsible for overseeing the insurance company is the Autorité de Contrôle Prudentiel de Résolution (ACPR) (Supervisory Authority for Prudential Resolution) - Insurance Sector, located at 4 place de Budapest – CS 92459- 75436 PARIS Cedex 09.

GLOSSARY

ACCIDENT

Any bodily injury caused by a violent sudden and unpredictable external action.

MEDICAL ACTS AND CONSULTATIONS OUTSIDE OF HEALTHCARE CHANNELS

The following are addressed:

- Medical treatment or consultations for an insured person over 16 years of age who has not declared an attending physician to his/her health insurer.
- Medical treatment or consultations carried out which have not been prescribed by the attending physician declared to the health insurer by the insured person who is over 16 years of age.

The increased costs of participation and the authorised excess fees whether or not connected with observing the treatment procedure are reimbursable in part, according to the table of services and the subscribed guarantees.

ADHERENT

The person who is a member of the Association and who adheres to the contract.

INSURED PERSONS

The persons relying on the insurance, namely the Adherent (unless stated to the contrary in the certificate of adherence) and the members of his/her Family meet the conditions in order to be insured.

BASIS OF REIMBURSEMENT

The reference rate for mandatory health insurance which serves to determine the amount of reimbursement.

SUPPLEMENTAL HEALTH INSURANCE

All of the guarantees assuring coverage for a person and/or his/her family, for all or part of the costs connected with health care, in addition to or as a supplement to the services of the mandatory health insurance system.

NON-RESPONSIBLE CONTRACT

The adherence does not meet all or part of the criteria for a "Responsible Contract" as defined below. In this case, the guarantees of the contract may be reimbursed in whole or in part:

- the increased costs of the nominal fee ("ticket modérateur") in the event of a failure to observe the care procedure.
- the "uncovered portion" of the excess fee authorised for the specialists consulted outside of the care procedure and within the limits of the chosen guarantees.

On the other hand, they do not reimburse the fixed participation and the medical deductibles.

RESPONSIBLE CONTRACT

The Law describes a private health insurance contract as "responsible" when it encourages the observance of coordinated medical care (the coordinated care is based on the choice of an attending physician that the insured party has designated to his/her health insurer). In this case, the guarantees of the contract provide for minimum obligations of reimbursement for services connected with consulting the attending physician and his/her prescriptions and it covers at least two preventative services as established by regulations. They also provide for coverage of:

- the average cost for all categories of care, with the exception of spa therapy, homeopathic medications and medications reimbursed at 15% and 30%,
- the daily hospital cost invoiced by health establishments, without any duration limitation.

They comply with the provisions of 100% Health Care (no deductibles).

However the following are not covered:

- Extra charges or increase in costs resulting from a failure to comply with the medical treatment,
- The fixed participation of €1 applicable to consultations and certain medical examinations,
- Deductibles applicable to medication, paramedical actions and transport fees (for example: €0.50 per box of medication).

PRICE REGULATION FACILITY (DISPOSITIF DE PRATIQUE TARIFAIRE MAÎTRISÉ) (DPTAM)
A Price Regulation Facility is a contract offered to doctors by the Social Security Service which proposes that they limit their excess fees in exchange for a certain number of advantages. The Care Access Contract (Contrat d'Accès aux Soins (CAS)) and the Regulated Price Option (Option Pratique Tarifaire Maîtrisée (OPTAM)) are two facilities for regulating prices.

FAMILY
The insured Adherent, his/her spouse (or the person connected by a civil solidarity pact (PACS) or the common-law spouse) and (first-degree) descendants or ascendants, or those of his/her spouse.

DAILY HOSPITAL RATE
Amount due for any hospital stay with a duration of greater than 24 hours in a health institution. This is a fixed participation by the patient in the hospitalisation costs and the care costs incurred by his/her hospitalisation.

HOSPITALISATION
Designates a stay in a health care establishment with a view to medical treatment of an illness, an accident or maternity.

ILLNESS
Any health change certified by a competent health authority.

COMPULSORY PARTICIPATION OF €1
The compulsory contribution of €1 is paid by the patient towards all medical treatment and consultations with a doctor as well as biological and radiological tests.

REMAINDER
The portion of the health costs which remain for the insured party to pay after reimbursement by the the mandatory health insurance. This consists of:
- the nominal fee,
- possible deductibles or fixed participations,
- possible excess fees.

STAYS IN SPECIALISED ESTABLISHMENTS
Stays in specialised establishments for rest, rehabilitation (including stays contributing to treating alcoholism and drug abuse), convalescence, geriatrics, neuro-psychiatry, psychiatry, dietary treatments, and similar stays, regardless of the establishment, as well as stays at children's homes of a health or social benefits character.

NOMINAL FEE (TICKET MODÉRATEUR)
This is the difference between the basis of reimbursement and the amount reimbursed by the health authority (calculated before applying the compulsory contribution of one euro or the deductible). The nominal fee is usually covered by the complementary health insurance.

100% HEALTH CARE ("100% SANTÉ")
The mechanism by which the insured persons covered by a responsible supplemental health care contract may benefit from certain services for optics, hearing aids, and dental prostheses, fully reimbursed by the mandatory heath insurance and the supplemental health care policies, without any additional costs, provided that the health care professionals observe the maximum set rates.
For these identified services (designated by the "100% Health Care" symbol or "reinforced coverage act") which are defined by regulations, opticians, audio-prostheses, and dental surgeons set their prices within the limit of the pre-defined caps and undertake to observe the conditions of the 100% Health Care offer.
The responsible supplemental health care contracts reimburse the difference between the price invoiced by the optician, the audio-prosthesis provider or the dental surgeon, and the amount reimbursed by the mandatory health insurance service, within the limit of the tariff caps pre-defined for the acts in the 100% Health Care category.
Opticians and audio-prosthesis providers are required to propose equipment covered by the 100% Health Care category and to prepare an estimate that systematically indicates equipment in the 100% Health Care category.
As for dental surgeons, they have the obligation, when they propose to their patients to perform an act that is outside of the 100% Health Care category, to also propose to them a therapeutic alternative that is provided for in the 100% Health Care category whenever such an alternative exists, or if not available, to offer to them an alternative with a limited uninsured portion. Dental surgeons are also required to deliver an estimate to the patient for dental prostheses.

BRITISH HEALTH WAYS 4

TABLE OF SERVICES

HOSPITALISATION

HOSPITALISATION	No Frills TEXA	Basic TEXB	Comfort TEXC	Extra-Comfort TEXD
Fees of the physicians who have joined the DPTAM (Dispositif de Pratique Tarifaire Maîtrisé - Mechanism for Practising Capped Fees) who have not joined the DPTAM	100% 100%	150% (1) 130% (1)	200% (1) 180% (1)	250% (1) 200% (1)
Loyalty bonus from the third year onwards on the fees of doctors who have or have not joined the DPTAM (limited to 200% of the Social Security tariff for practitioners who have not joined the DPTAM).	+50%/year (max 150%)	+50%/year (max 200%)	+50%/year (max 300%)	+50%/year (max 400%)
Costs for hospitalisation in an approved establishment	100%	Actual costs		
in a non-approved establishment	100%	100%	100%	100%
Daily hospitalisation fees	Actual costs			
Private room (including outpatient) not reimbursed by the mandatory regime approved establishment non-approved establishment	Not covered Not covered	Actual costs €35 /day	Actual costs €45 /day	Actual costs €55 /day
		Limited to 60 days / year / beneficiary for stays in specialised establishments		
Accompanying bed, child or adult	Not covered	€12 /day	€15 /day	€20 /day
		Limited to 60 days / year / beneficiary		
Home Care	100%	125%	150%	175%
MEDICAL TRANSPORTATION				
Transport prescribed for hospitalisation or ambulatory care (city medicine)	100%	100%	100%	100%

ONGOING CARE

	TEXA	TEXB	TEXC	TEXD
Medical fees: Consultations, medical acts (x-ray, minor surgery) and visits to general practitioners and specialists who have joined the DPTAM who have not joined the DPTAM	100% 100%	150% 130%	200% 180%	250% 200%
Laboratory analyses and examinations: biology, medical analysis	100%	100%	125%	150%
Para-medical fees: Medical auxiliaries (nurses, midwives, physical therapists, speech therapists, orthoptists)	100%	100%	125%	150%
Support sessions carried out by a psychologist and paid for by the mandatory regime.	100%	100%	100%	100%
Medications reimbursed by the mandatory regime	100%	100%	100%	100%
Medical equipment: Devices or prostheses (except for eye glasses and hearing aids), as defined in the list of products and services reimbursable by the mandatory regime	100%	125%	150%	175%
Prescription pharmacy not reimbursed by the mandatory regime: Smoking cessation (all nicotine-based medicines and products prescribed by a doctor for the purpose of smoking cessation (with a Marketing Authorisation or AFNOR standard and not reimbursed by the mandatory regime), medicines, homeopathy (purchased in physical pharmacies or online)	Not covered	50% of actual costs cap of €25/year	50% of actual costs cap of €30/year	50% of actual costs cap of €40/year
Alternative medicine: (osteopath, chiropractor, acupuncturist, pedicure-podiatrist, etiopath, homeopath, dietician-nutritionist, psychologist, sophrologist, naturopath) not reimbursed by the mandatory regime	€100/year	€100/year	€100/year	€100/year
Prescribed, non-reimbursed vaccinations	€75/year	€100/year	€100/year	€150/year
Reimbursed spa therapy	100%	100% + additional charge of €50/year	100% + additional charge of €100/year	100% + additional charge of €150/year

CARE PROVIDED ABROAD

	TEXA	TEXB	TEXC	TEXD
Care provided abroad	100%	100%	100%	100%

OPTICAL CARE

	TEXA	TEXB	TEXC	TEXD
100% Health Care equipment (2) Eye glasses: 100% Health Care class A lenses and frames, as defined by the regulations	Actual costs within the limit of the prices defined by the regulations			
Equipment at unregulated prices (2)				
• Equipment with two class B (3) simple lenses for the first 2 years of adherence	100%	€50	€100	€150
starting from the 3rd year	100%	€100	€200	€300
• Equipment with a simple lens and a class B (3) complex/very complex lens for the first 2 years	100%	€125	€150	€200
starting from the 3rd year	100%	€160	€250	€350
• Equipment with 2 class B (3) complex/very complex lenses for the first 2 years	100%	€200	€250	€300
starting from the 3rd year	100%	€200	€350	€450
The prices in euros include the reimbursements for the mandatory regime				
Mixed equipment (2) In the event of a mixture of 100% Health Care equipment and non-regulated price equipment (for example, a frame that is 100% Health Care + 1 lens that is non-regulated + 1 lens 100% Health Care), the 100% Health Care equipment is reimbursed in the amount of the actual cost up to the limit of the prices defined by the regulations. The reimbursement of non-regulated price equipment is reduced by the reimbursement granted for 100% health care by the mandatory regime and the supplementary regime. If the frame is at an unregulated price, the reimbursement for it may not exceed €100.				
Contact lenses (4)	100%	€75/year	€100/year	€150/year
Laser operations not reimbursed by the mandatory regime (per eye)	Not covered	€75/year	€100/year	€150/year

The guarantees are expressed as a percentage of the reimbursement basis of the Social Security Service, in a fixed Euro amount, or in a combination of the two. They include the reimbursements from the mandatory regime (the fixed amounts expressed in Euros are understood to be per insured person and per insurance year, unless specifically indicated, and cannot be carried forward from one year to the next). Only the costs which have first resulted in a reimbursement by the French mandatory insurance regime are taken into consideration (except when this is explicitly stated in the table of guarantees).
The total of the reimbursements received by the Insured Person may not in any case exceed the actual costs incurred. The benefits set out in the table above are to be understood in all cases according to the terms and conditions of the contract. In accordance with the regulations, the fixed participation and the deductibles for medications, acts performed by a medical auxiliary, and transportation, as well as an increase in the nominal fee and the authorised excess fees in the case of not complying with the treatment procedure, are not covered.

DENTAL

	TEXA	TEXB	TEXC	TEXD
Treatment: reimbursed consultations and care, inlay- onlay, surgery, and periodontics	100%	100%	150%	200%
100% Health Care treatment and prostheses These prostheses include certain ceramic/metallic crowns on incisors, canines and pre-molars, certain metallic crowns on other teeth (refer to the information notice to find the references specific to the regulations)	Actual costs within the limit of the prices defined by the regulations			
Other prostheses (prostheses with limited prices and non-regulated price prostheses) These include certain ceramic/metallic crowns on 2nd pre-molars and molars, certain bridges, certain removable devices, implants and other prostheses defined as having limited prices or non-regulated prices	100%	100%	150%	200%
Loyalty bonus from the 3rd year onwards for dental prostheses at limited and non-regulated prices and Orthodontics	+€50 / year for 3 years (i.e. a maximum bonus of €150)			
Orthodontics	100%	100%	150%	200%
Orthodontics, periodontics and implants not reimbursed by the mandatory regime (5)	Not covered	€100/year	€150/year	€200/year

HEARING AIDS

	TEXA	TEXB	TEXC	TEXD
100% Health Care equipment 100% Health Care hearing aids (Class I) (6)	Actual costs within the limit of the prices defined by the regulations			
Hearing aids at non-regulated prices (Class II) (6) Adult (>20 years) Child The prices in € include the reimbursements for the mandatory regime	€400 €1,400	€500 €1,700	€600 €1,700	€700 €1,700
Repairs and batteries for hearing aid	100%	125%	150%	175%

EXONERATION FROM AND/OR REIMBURSEMENT OF PREMIUM

	TEXA	TEXB	TEXC	TEXD
In the case of hospitalisation for more than 9 consecutive nights as the result of an accident (reserved for insured persons who do not benefit from the "Madelin law")	guarantee			

ASSISTANCE

Only the AXA Assistance teams are authorised to determine the duration of the services (7)

	TEXA	TEXB	TEXC	TEXD
Home help following hospitalisation or during immobilisation for more than 8 days	One time per year up to a limit of 30 hours			
Child care during hospitalisation of more than 5 days	One time per year up to a limit of 40 hours			
Care for sick children during immobilisation of more than 8 days	One time per year up to a limit of 40 hours			
Animal care during hospitalisation of more than 24 hours	One time per year within the limit of €229			
Educational support as a result of immobilisation at home	One time per year up to a limit of 5 hours (primary school) or 10 hours (secondary school) per week for 2 months			

ADDITIONAL COVER

HOSPI (RH)

Hospitalisation: fees of doctors who have or have not joined the DPTAM (reimbursement is always limited to 200% of the Social Security rate if the doctor has not joined the DPTAM).	+50 % (8)

OPTICAL CARE / DENTAL CARE (ROD)

Optical care: Equipment at non-regulated prices (regardless of correction).	+€50

Dental prostheses with limited or non-regulated prices	+50 %
Orthodontics reimbursed by the mandatory regime	+50 %

(1) For the first month of insurance, the rate of reimbursement is limited to 100% except in the case of an accident, in this case the entire rate is applied (in the case of full renewal without interruption of the guarantee, it is the rate of the previous contract that is applied within the limits provided for in the table of services). This applies to the subscription of the contract and at the time of adding a new beneficiary, with the exception of new-born children. **(2)** The coverage for eye glasses is limited to one pair every 2 years (except for children under the age of 16 years or in the event of change of vision, then limited to one pair per year). The change of the correction must be justified by providing a new medical prescription or a supporting document by the optician. The point of departure for the renewal is the date of the first equipment. For insured persons with presbyopia who do not want or cannot have progressive lenses, it is possible to have one set of glasses for distance vision and one set for near vision every 2 years. The amount reimbursed for one pair of eye glasses is in all cases limited to the caps defined by the regulations for responsible contracts. **(3)** The eye glasses fixed fee includes the reimbursement of the frame and the lenses. The reimbursement for the frame may not exceed € 100, even if the fixed amount exceeds this. **(4)** Prescribed contact lenses are covered even if they are not reimbursed by the Social Security. The nominal fee for the contact lenses reimbursed by the Social Security Service is covered, even if the annual fixed amount has been exhausted. **(5)** This package cannot be used for care not included in the Common Classification of Medical Procedures (CCAM). **(6)** The coverage for hearing aids is limited to one device per ear every 4 years. For hearing aids with non-regulated prices, in accordance with the regulations on responsible contract, the coverage is limited to € 1,700 per ear (regardless of the age of the beneficiary). This cap is calculated taking into account the reimbursement by the mandatory regime. **(7)** Refer to the Assistance conditions and guarantees, page 19. **(8)** For the fees of doctors who have not joined the DPTAM at the No Frills level, the reimbursement increases are capped at +30% for the Hospi additional cover.

DEFINITIONS

Simple lenses:
- unifocal spherical lenses where the sphere is between – 6.00 and + 6.00 dioptres
- unifocal spherical-cylindrical lenses where the sphere is between – 6.00 and 0 dioptres and the cylinder is less than or equal to + 4.00 dioptres
- unifocal spherical-cylindrical lenses where the sphere is positive and the S total (sphere + cylinder) is less than or equal to 6.00 dioptres

Complex lenses :
- unifocal spherical lenses where the sphere is outside the zone of – 6.00 and + 6.00 dioptres
- unifocal spherical-cylindrical lenses where the sphere is between – 6.00 and 0 dioptres and the cylinder is greater than + 4.00 dioptres
- unifocal spherical-cylindrical lenses where the sphere is less than – 6.00 dioptres and the cylinder is greater than or equal to 0.25 dioptres
- unifocal spherical-cylindrical lenses where the sphere is positive and the S total is greater than 6.00 dioptres
- multifocal or progressive spherical lenses where the sphere is between – 4.00 and + 4.00 dioptres
- multifocal or progressive spherical-cylindrical lenses where the sphere is between – 8.00 and 0.00 dioptres and the cylinder is less than or equal to + 4.00 dioptres
- multifocal or progressive spherical-cylindrical lenses where the sphere is positive and the S total is less than or equal to 8.00 dioptres

Very complex lenses:
- multifocal or progressive spherical lenses where the sphere is outside the zone of – 4.00 and + 4.00 dioptres
- multifocal or progressive spherical-cylindrical lenses where the sphere is between – 8.00 and 0 dioptres and the cylinder is greater than + 4.00 dioptres
- multifocal or progressive spherical-cylindrical lenses where the sphere is less than – 8.00 dioptres and the cylinder is greater than or equal to 0.25 dioptres
- multifocal or progressive spherical-cylindrical lenses where the sphere is positive and the S total is greater than 8.00 dioptres

BRITISH HEALTH WAYS 4

INFORMATION NOTICE

ARTICLE 1 - PURPOSE OF THE CONTRACT

The purpose of the contract is to guarantee the reimbursement of the following for the Adherent and his/her insured family:
- medical and surgical expenses caused by an illness, an accident, as a complement to the benefits paid by their mandatory health insurance scheme.
- expenses for treatment which are not covered by the health system but included in the guarantees of the contract.

ARTICLE 2 – TERMS FOR ADHERING TO THE CONTRACT

The contract is composed of the request for adherence, the certificate of adherence and this information notice.

2.1 - CONDITIONS OF ADHERENCE

Subject to acceptance by the Association, anyone may adhere to the contract who:
- is less than 91 years old (by year of birth) at the time of adherence
- is affiliated with one of the following mandatory regimes of the Social Security Service:
  - general regime of the Social Security Service and the related regimes;
  - regime for agricultural employees and agricultural operators.
- has submitted to the Association a duly completed and signed application stating each member of the family to be covered as well as the level of guarantee chosen for the entire family,
- has paid the 1st premium, including the registration fees.
- has paid the associated fees for which the amounts are specified in article 6.3 of this information notice.

Persons who are already covered by another private health insurance are not eligible.

2.2 - DURATION AND RENEWAL OF THE ADHERENCE

The adherence to the contract and the Association is effective for a minimum of one year and is automatically renewed until 1 January of the following year, then on each renewal date set as 1 January.

ARTICLE 3 – THE GUARANTEES

3.1 - START OF THE GUARANTEES

The guarantees take effect for each Insured Person as from the date indicated on the certificate of adherence subject to payment of the first premium; this date cannot be earlier than the date when the application was received by the Association.

3.2 - CHANGES TO THE LEVEL OF GUARANTEE

The services vary according to the level of guarantees offered, for which the details are set out in the table of services. Any decrease or increase in the level of guarantee is subject to acceptance by the Association. These requests may be accepted at least one year following adherence to the contract, and thereafter no reduction or increase in the level of the guarantee may be accepted before 12 months.
The modification concerns the Adherent and each Insured Person appearing in the contract, if any.

3.3 END OF THE GUARANTEES

The guarantee shall terminate for you and your dependants:
- on 31 December of the insurance year during which you no longer meet the conditions for adherence,
- in the event of the termination of your adherence, in application of the provisions provided for in Article 7 – "Termination of the Adherence,"
- in the event of ceasing to pay the premiums, according to the terms of Article 6 "Premiums."

The cessation of the guarantees for you shall cause the cessation of the guarantees for your dependants. However, when the cessation of the guarantees results from your death and provided that your surviving spouse (or the person linked by a civil solidarity pact (PACS) or the common-law spouse) continues to pay the premiums corresponding to the guarantees that he/she enjoys, these guarantees shall be maintained for him/her and your children.

Once your adherence is registered, you may not be excluded against your will provided that you comply with the conditions for adherence, except in the case of failure to provide information, an omission, a false or inaccurate declaration made in bad faith, and provided that the premium has been paid.

3.4 - DESCRIPTION OF THE GUARANTEES

This additional health insurance contract is considered to be a "responsible contract," in accordance with Article L871-1 of the French Social Security Code and its application decrees.

The reimbursements for treatment costs are always carried out in addition to the reimbursement by the mandatory scheme and within the limit of costs actually incurred and within the limits and amounts set out in the table of services. This table of services, which forms an integral part of this information notice, details the amount of the reimbursements according to the level of guarantee subscribed. In the context of the reform known as 100% Health Care ("100% Santé") and in application of the Decree No. 2019-21 of 11 January 2019, the health care expenses incurred in connection with 100% Health Care devices are fully covered within the limit of the sales prices set for these devices and after deduction of the reimbursements by the mandatory regimes.

Only the health care costs defined in the table of guarantees and which result from a generating event taking place between the effective date and the termination date of the contract shall be reimbursed.
A generating event is considered to be:
- for health care costs in general: the date of the care that appears on the reimbursement statement of the Social Security
- for guarantees connected with hospitalisation: the date of entering the hospital establishment that appears on the statement of hospitalisation
- for orthodontic treatments: the date of the end of the treatment which appears on the statement of the Social Security.

Certain reimbursements are also governed by the following provisions.

3.4.1 – HOSPITALISATION

Fees: For the first month of insurance, the rate of reimbursement is limited to 100% except in the case of an accident, in this case the entire rate is applied (in the case of full renewal without interruption of the guarantee, it is the rate of the previous contract that is applied within the limits provided for in the table of services). This applies to the subscription of the contract and at the time of adding a new beneficiary, with the exception of new-born children.

Private room (in the case of subscribing for guarantee levels Basic, Comfort or Extra-Comfort): In order to benefit from this guarantee, the Insured Person must choose an accredited or approved establishment. For stays in specialised establishments, the reimbursement is limited to 60 days per calendar year and per insured person for guarantee levels 2 through 4.

Accompanying bed (in the case of subscribing for guarantee levels Basic, Comfort or Extra-Comfort): In order to benefit from this guarantee, the Insured Person must choose an accredited or approved establishment. The reimbursement is limited to 60 days per year and per insured person.

Daily hospitalisation fees: Reimbursement for any hospitalisation (medical, surgery, obstetrics, odontology and psychiatry).

Home hospitalisation: Reimbursement of care necessary for the beneficiary in connection with medical care or supervision.

3.4.2 – MEDICAL OPTICS

Since 1 January 2020:

- the equipment in the context of 100% Health Care are fully covered by the guarantees, subject to deduction of the reimbursement by the mandatory regime and within the limit of the sales prices set for this type of act in application of the Decree No. 2019-21 of 11 January 2019.
- equipment with unregulated prices is reimbursed within the limits and the amounts provided for in the table of services, subject to deduction of the reimbursement by the mandatory regime and within the limit set for this type of act in application of the Decree No. 2019-21 of 11 January 2019. The reimbursement of the frame may not exceed €100.
- in the event of a mixture of 100% Health Care equipment and non-regulated price equipment (for example, a frame that is 100% Health Care + 1 lens that is non-regulated + 1 lens 100% Health Care), the 100% Health Care equipment is reimbursed in the amount of the actual cost up to the limit of the prices defined by the regulations. The reimbursement of non-regulated price equipment is reduced by that granted for equipment that is 100% Health Care. If the frame is at an unregulated price, the reimbursement for it may not exceed €100.
- the coverage of eye glasses is limited to one pair every 2 years for persons aged 16 years and over. It is limited to one pair per year for children aged 15 and under in application of the Decree No. 2019-21 of 11 January 2019. The coverage may be more frequent in the event of changes in sight or the inappropriateness of the equipment.*

* The change of the correction must be justified by providing a new medical prescription or a supporting document by the optician. The point of departure for the renewal is the date of the first equipment. For insured persons with presbyopia who do not want or cannot have progressive lenses, it is possible to have one set of glasses for distance vision and one set for near vision every 2 years. The conditions for renewal and coverage are set by Article VIII of the Decree of 13 December 2018.

3.4.3 – DENTAL

Since 1 January 2020:

- the prostheses in the context of 100% Health Care are fully covered by the guarantees, subject to deduction of the reimbursement by the mandatory regime and within the limit of the sales prices set for this type of act in application of the Decree No. 2019-21 of 11 January 2019.
- the prostheses with regulated prices are covered within the limits and the amounts provided for in the table of services, subject to deduction of the reimbursement by the mandatory regime and within the limit set for this type of act in application of the Decree No. 2019-21 of 11 January 2019.
- the prostheses with unregulated prices are covered within the limits and the amounts provided for in the table of services, subject to deduction of the reimbursement by the mandatory regime.

3.4.4 – HEARING AIDS

Since 1 January 2021:

- hearing aids in the context of 100% Health Care are fully covered by the guarantees, subject to deduction of the reimbursement by the mandatory regime and within the limit of the sales price set for this type of act in application of the Decree No. 2019-21 of 11 January 2019.
- hearing aids with unregulated prices are reimbursed within the limits and the amounts provided for in the table of services, subject to deduction of the reimbursement by the mandatory regime and within the limit set for this type of act in application of the Decree No. 2019-21 of 11 January 2019.
- the coverage for hearing aids is limited to one device per ear every 4 years, in accordance with the Decree No. 2019-21 of 11 January 2019.

3.4.5 – MISCELLANEOUS

Exoneration from (or reimbursement of) the premium (reserved for Insured Persons who do not benefit from the "Madelin law"): The exoneration from or the reimbursement of the family premium for the calendar year in progress shall take place in the event of the hospitalization of the Adherent or his/her registered spouse (or the person linked by a civil solidarity pact (PACS) or the common-law spouse) for a duration equal to or greater than 9 consecutive nights (the date of entry into the hospital will be used as the calendar year). This hospitalisation must be the direct consequence of an accident and must start within 90 days of that event.

3.4.6 - ADDITIONAL COVER

Subscription to one of the two or two different optional reinforcements is compulsory for the whole family and can be done at the time of subscription or during the life of the agreement (in accordance with Article 3.2). It makes it possible to improve the level of reimbursement of certain benefits provided for in the level of cover subscribed to and defined in the annex to the table of service.

Option "Hospi Additional Cover (RH)": This option can be taken out at the time of adherence or during the life of the contract (in accordance with Article 3.2). This Hospi option improves the reimbursement provided for in the subscribed level for medical fees (during hospitalisation).

Option "Optical care / Dental care Additional Cover (ROD)": One of these options can be taken out at the time of adherence or during the life of the contract (in accordance with Article 3.2). These options allow the reimbursement provided for in the subscribed level to be improved
for:

- optical equipment at non-regulated prices;
- orthodontics reimbursed by the mandatory regime and prostheses at non-regulated and/or regulated prices.

3.5 - EXCLUSIONS AND LIMITATIONS

3.5.1 - GENERAL EXCLUSIONS

The following are excluded from any reimbursement:

- **The effects of civil war or foreign war, uprisings and civil movements, as well as the direct or indirect effects resulting from radioactivity or nuclear reaction, in accordance with the Insurance Code;**
- **Acts that are not recognised by the mandatory regimes, acts not provided for in the table of services, cosmetic surgery or care that are not reimbursed by the mandatory regimes,**
- **Treatments prior to the effective date of the adherence;**
- **Costs that were subject to an administrative refusal by the Social Security Service;**
- **Long-stay hospitalisation costs, namely care including lodging for persons who do not have living autonomy and whose condition requires constant medical supervision and maintenance treatments, and the care invoiced by medical/social establishments such as specialised homes (MAS) or establishments for the housing of dependent persons (EHPAD);**
- **Stays in health care establishments begun before the effective date of the adherence;**
- **Care provided 2 years before the date when they were presented;**
- **Costs for which you have not provided the requested supporting documents (if the statement of your mandatory regime is not sufficient, you must provide us with additional supporting documents: invoice, prescription, fee note);**
- **Penalties applied by the Social Security Service for failure to comply with the treatment procedure: increase of the nominal fee, authorised increase in the agreed tariffs;**
- **Fixed participation and the deductibles for medications, para-medical acts and medical transportation;**
- **Penalties applied by the Social Security Service for failure to comply with the treatment procedure: increase of the nominal fee, authorised increase in the agreed tariffs.**
- **health costs that have already been reimbursed by another complementary health insurance scheme**

3.4.2 - SPECIFIC EXCLUSIONS

The following are excluded:

- **In the event of a failure to observe the coordinated care programme and/or a refusal by the insured party to authorise access to his/her personal medical file (DMP) for the healthcare professional, the non-reimbursable amounts addressed by articles 20 and 57 of the Law of 13 August 2004 and its decrees, namely:**
  - **the increase of the participation by the Adherent,**
  - **the authorised excess fees.**
- **The "premium exemption" guarantee for insured persons benefiting from the "Madelin law".**

3.4.3. LIMITATIONS

Our coverage of plastic surgery reimbursed by the mandatory regimes is limited to the nominal fee, unless it is connected with an accident or the consequences of a documented pathology. In these cases, the rates of the table shall apply. This limitation is applied both to hospitalisation and out-patient services.

3.6 - TERRITORIALITY

The guarantees are applicable in France and in other countries when the French mandatory regime guarantees medical costs. The reimbursement for services is paid in France, in the legal currency in use in France. If necessary, all supporting documents must be translated and the amounts converted into the legal currency in use in France.

ARTICLE 4 – SERVICES

4.1 - "TELETRANSMISSION" AND "TIERS PAYANT"

Conditions to observe for the two services above: send to the Association, in its capacity as manager, a copy of the Carte Vitale (Social Security attestation) for each of the members of the family.

4.1.1 - TELETRANSMISSION WITH THE MANDATORY REGIMES

The statements of reimbursements for the Insured Persons may be transmitted in the form of computer image files to the Association directly by the health authority, so that the Insured Person does not have to send by post the statement of the reimbursement to the Association. In this case, a statement of the type:
"... transmitted by your health insurance fund to your supplemental insurer" must appear on your statement. The Insured Person may at any time, upon written request to the Association, terminate these transmissions.

4.1.2 - "TIERS-PAYANT SANTÉ" (THIRD PARTY HEALTH CARE PAYMENT)

This allows the Insured Person not to have to make advance payment for the costs to the care providers. It functions by simply presenting the Attestation de Tiers Payant Santé (ATPS) and, in the context of a responsible contract, it allows for the equivalent immediate coverage of at least the nominal fee. In order to benefit from this, the healthcare expenses must be covered by the third party payer, the healthcare professional must also accept the third party payer along with the mandatory regime and the guarantee must provide at least for the nominal fee (excluding pharmacy if stated specifically on the ATPS).

4.2 - "PRISE EN CHARGE" (COVERAGE)

The Insured Person may benefit from direct coverage by the Association, in its capacity as manager, at his/her request or at the request of the professional in question within the limits provided for in the table of services, for all of the following items:

- Hospitalisation: costs of stay within the limit of 100% of the reimbursement base, daily hospital rate, private room and accompanying bed (Hospitalisation cover may only be provided for medical or surgical stays in a public hospital or approved clinic).
- Dental: prosthesis, orthodontics, implants and periodontics.
- Optical: lenses, frames and contact lenses accepted by the mandatory regime, as well as laser operations, AMD treatment, and multifocal intra-ocular implants, if they are provided for in the table of services.
- Medical equipment: orthopaedics costs, devices and prostheses other than dental.

4.3 - ITELIS SERVICE

You benefit from numerous advantages in the following domains: optical, dental, audio-prostheses, refractive surgery.

Method of use

1 - Locate the closest partner:

- By internet from the personalised Client Space

- By telephone by calling the management centre on the number appearing on your Certificate of Third Party Health Payer (Attestation de Tiers Payant Santé),

2 - Present to the partner your third party payer card on which the Itelis statement appears,
3 - Request to benefit from the advantages of the Itelis network.

4.4 - HOSPIWAY SERVICE

Hospiway® is an information service to help you better prepare for your hospitalisation or that of a relative. This site is accessible from the personalised Client Space.

This site offers:

- access to a Hospitals and Clinics Guide providing a classification of the best French health care establishments for the care of numerous pathologies.
- a choice of a health care establishment meeting your expectations by consulting the national classification or by searching for an establishment in a given geographic zone,
- an analysis of their quotations on the basis of the planned acts. The possible excess fees may be evaluated by comparing them with those currently applied in a given geographic zone,
- better prepare themselves or someone close for their hospital stay and their return home thanks to a Check List containing practical advice.

4.5 - MEDICAL TELE-CONSULTATION

"Tele-consultation" is a service for remote medical consultation which was put in place by and is entrusted to INTER PARTNER ASSISTANCE (AXA Assistance, 6 rue André Gide -92320 Châtillon, - 311 338 339 RCS Nanterre).
This activity by AXA Assistance is officially registered, in accordance with the Decree No. 2010-1229 of 19 October 2010 concerning tele-medicine, and is performed on the basis of a contract concluded with the appropriate Agence Régionale de Santé (ARS) (Regional Health Agency). A failure by the ARS to renew this contract will constitute a case of force majeure causing the termination of the tele-consultation guarantee without advance notice and without all of the other provisions of your contract being modified.
The premium corresponding to this guarantee is included in the premium for the contract and the corresponding service is included in the service charges.

Definitions
Medical Team or Team of Doctors: The Doctors or State Certified Nurse (IDE - Infirmier Diplômé d'Etat) employed by AXA Assistance
Doctor: General practitioner
Tele-consultation: a medical consultation by telephone and additionally by video conference

Purpose
Tele-consultation is accessible by means of the telephone platform of AXA Assistance and is composed of a State Certified Nurse (IDE) and Doctors registered with the Conseil de l'Ordre des Médecins (French Medical Board). The Nurses and the Doctors are subject to medical secrecy.

Implementation of the guarantee
AXA Assistance responds 24 hours per day and 7 days per week to the telephone calls that it receives.
The tele-consultation as described below functions identically for you and for each of the Insured Persons under the contract. It is however specified that when this concerns a tele-consultation for a minor child or for an adult under guardianship insured under contract, the call may be made by the person holding parental authority or guardianship.
Depending on your needs or the needs of the beneficiary, the responses may be of 3 types: tele-consultation, general health information or orientation to further care.

Tele-consultation
In the event of the absence or unavailability of the official treating physician and outside of any emergency, you may contact the services of AXA Assistance in order to benefit from a Tele-consultation.
The Team of Doctors may be contacted 24 hours per day and 7 days per week in order to provide you with a Tele-consultation in accordance with the legal provisions concerning medical secrecy.
In order to call us, be sure to have your Third Party Payer Health Certificate (Attestation de Tiers Payant Santé) for identification purposes, and dial the direct telephone number:

3633 from France (toll-free number)
and +33 1 55 92 27 54 from abroad

This number is strictly reserved for tele-consultation and will consequently not allow us to respond to any other requests. A State Certified Nurse (IDE) will receive your call. After having informed you of the terms for providing the Tele-consultation and after receiving your consent, the Nurse will register your request and will put you in contact with a Doctor for AXA Assistance who will undertake the Tele-consultation.
The video conference will allow the telephone communication to be completed by visual communications. The images from the video conference will not be used for the purposes of diagnosis. During the Tele-consultation, you will have the possibility to send to the Doctor documents (photos, biological analyses, etc.) that may complete the information that you have communicated orally. The Doctor may possibly use these documents in support of his diagnosis.
Following the Tele-consultation, the Doctor for AXA Assistance will provide you with a medical response adapted to your pathological situation.

This response may take the following form:

- Advice to contact your treating physician,
- Orientation to one of the following specialists, in observance of the treatment procedure: gynaecologist, ophthalmologist, stomatologist, psychiatrist or neuropsychiatrist for an insured person between the ages of 16 and 25 years,
- Written medical prescription or additional examinations if you are located in a country of the European Union.

The Doctor for AXA Assistance is the sole person to make a decision following the completion of the Tele-consultation.
If the Medical Team of AXA Assistance identifies a medical emergency, you will be immediately re-directed to the emergency services.

Following the Tele-consultation and with your authorisation, a report of the consultation may be sent to your treating physician, if the Doctor for AXA Assistance considers that there is a medical interest for this transmission.
Attention: In certain cases, a physical examination may be necessary in order to establish a diagnosis. If necessary, the Doctor for AXA Assistance will re-direct you to your treating physician.
The Tele-consultation guarantee is limited to 12 calls per year and per beneficiary.

Information
At your request, the Medical Team of AXA Assistance may communicate the information 7 days per week and 24 hours per day. It will provide any information of a general nature. The intervention by the Medical Team of AXA Assistance is limited to providing objective information. The purpose of the Tele-consultation is not in any case to favour any self-medication.

Orientation
At your request, the Medical Team of AXA Assistance may help you to exercise your free choice by advising you concerning a selection of specialist physicians and/or health care establishments, in observance of the treatment procedure.

Exclusions
The following are excluded from Tele-consultation:
- Tele-consultations when the Medical Team of AXA Assistance identifies a medical emergency,
- requests for Tele-consultations with any doctor other than a General Practitioner,
- prescriptions for the renewal of treatment in the case of chronic pathologies,
- work stoppage prescriptions,
- medical certificates.

Responsibility
✓ Responsibility of AXA Assistance
The obligations subscribed by AXA Assistance in order to implement Tele-consultations under the terms hereof constitute obligations of means.
In this context, AXA Assistance may not, in particular, be held responsible for service interruptions and/or damages resulting from:
- failures or interruptions of the telephone and/or computer networks,
- changes in the situation of the Beneficiary and, in particular, changes in his/her state of health that have not been brought to their attention at the time of the Tele-consultation,
- a case of force majeure or the effects of a third party.

✓ Responsibility of the Beneficiary
The Beneficiary is responsible for the accuracy and the updating of the information requested at the time of the Tele-consultation in order to allow AXA Assistance to perform its commitments under good conditions.

Protection of personal data
In accordance with the regulations in force concerning the protection of personal data, AXA Assistance hereby informs you in its capacity as data controller that:
- the responses to the questions that are raised during a call by the Medical Team, after receiving your consent for the collection of health data, are necessary in order to process your file,
- the purpose of the processing is the Tele-consultation,
- the recipients of the data concerning you are the Doctors and Nurses of AXA Assistance, the pharmacies, and, with your consent, the treating physician and the approved health care data host.

INTER PARTNER ASSISTANCE undertakes the Guarantees of Assistance as set out in Article 7 below.

Claims and Disputes
✓ Processing of your claims
AXA Assistance shall ensure providing quality service to you. If, after having contacted AXA Assistance by telephone, a misunderstanding continues, you may write to the Medical Management (Direction Médicale) of AXA Assistance in a letter marked confidential at 6 rue André Gide – 92320 Châtillon. Your situation will be examined with the greatest care and a response will be sent to you as soon as possible.

✓ Disputes
Any disputes which may arise in connection with this Article concerning its validity, interpretation, performance and its consequences and the results thereof shall be submitted to the competent courts under the conditions of standard law.

4.6 - EASY SANTÉ ASSISTANCE
Treatment is good, prevention is better. The digital prevention programme My Easy Santé helps you to protect and improve your health on a daily basis and to reduce your risk factors.

My Easy Santé is an application that is simple to download or is accessible on myseasysante.fr. With My Easy Santé you will find:
- Tests designed by the best medical experts to determine your health age and to discover the programme appropriate for your needs.
- A selection of tested and approved coaching programmes, with exclusive reductions negotiated by AXA.
- The latest health care news in order to eat better, sleep better, move more and stay in shape.
- The possibility to connect to all of your connected devices for simple monitoring of your progress in real time.
- Good health tips for everyone and challenges to improve your health.
- Tele-consultation accessible at any time for medical assistance throughout the programme.

4.7 PERSONAL HEALTH ASSISTANT (ANGEL)
The Personal Health Assistant (ANGEL) is a service available to you or your potential beneficiaries to provide you with documented answers to your general health and administrative questions.

4.7.1 DESCRIPTION AND METHOD OF USE
The Angel service is a multi-channel offer, accessible:
- through an instant messaging system installed in an internet site: Angel.fr
- by telephone, by dialling: 36 33.

The Angel service remains open 24/7 allowing you to ask questions at any time. You will receive an answer from the Angel team from Monday to Saturday from 9am to 7pm.

As a Beneficiary, you are the only one entitled to ask a question on your Angel space.
The Angel team answers :
- your general health questions;
- your social security and administrative questions;
- your questions about psychological care;

• your questions about nutrition.
The intervention of the Angel Team is limited to giving objective information without the aim of this service being to encourage self-medication.

4.7.2 ORIENTATION
The Angel Team can help you exercise your free choice in medical matters by advising you on a selection of specialist doctors and/or health establishments.
To meet your needs and if necessary, the personal health assistant can also put you in touch with the AXA Assistance medical team as provided for in Article 4.5 of this notice relating to teleconsultation.

4.7.3 EXCLUSIONS
THE FOLLOWING ARE EXCLUDED FROM THE ANGEL SERVICE:
• medical and personal diagnosis;
• administrative matters relating to health insurance contracts (reimbursement and estimates).

ARTICLE 5 – REIMBURSEMENT CONDITIONS

We reimburse treatments for which the date of performance appearing on the mandatory regime statement or the practitioner's invoice, as the case may be, is between the beginning and the end of the guarantee.

In order to obtain reimbursement, you must send us the original of the statement from your mandatory regime for any service that is subject to prior reimbursement by the Social Security Service.
If you benefit from tele-transmission, your mandatory regime will do this for you and will automatically transmit to us the necessary information. You will be informed of this by a note on your statement.
For guarantees that are not subject to reimbursement by your mandatory regime, you must send to us the detailed invoices paid in the name of the insured person.
For the following particular cases, you must send to us certain additional documents as indicated below:

THE SERVICES	THE DOCUMENTS TO TRANSMIT TO US
Alternative medicine	
In all cases	The original invoice with the ADELI No. of the practitioner
Prevention	
Vaccines that are not covered by the Social Security Service and prescribed by a doctor	The medical prescription and the original invoice
Transportation costs	
The original of the statement from the mandatory regime.	
Pharmacy	
Medications covered by the mandatory regime	The original statement from the mandatory regime (unless you use the third party payer option)
Medications and homoeopathy not covered by the Social Security Service and prescribed by a doctor	The medical prescription and the original invoice
Nicotine substitutes	The original of the statement from the mandatory regime or the medical prescription and the original invoice if they are not reimbursed by the Social Security Service

THE SERVICES	THE DOCUMENTS TO TRANSMIT TO US
Dental Care	
In all cases	The original of the statement from the mandatory regime
For prostheses, orthodontics, implants or periodontics	The original of the detailed invoice for all of the acts, stating in particular the numbers of the teeth treated
Optical Care	
For eye glasses	The original of the invoice stating the visual correction and the type of lens If necessary, a request for coverage
For contact lenses	The original of the medical prescription dating less than 2 years previously (or a photocopy in the case of a renewal) and for contact lenses that are not covered by the mandatory regime, the original of the invoice
In all cases	The original of the statement from the mandatory regime and the original invoice
Auditory Care	
In all cases	The original of the statement from the mandatory regime In the event of exceeding the rate of the mandatory regime, the detailed invoice If necessary, a request for coverage
Miscellaneous devices and prostheses (other than dental and auditory prostheses)	
In all cases	The original of the statement from the mandatory regime In the event of exceeding the rate of the mandatory regime, the detailed invoice If necessary, a request for coverage
Hospitalisation	
Depending on the type of invoicing of the establishment	The invoice statement directed to the supplemental health insurance The original invoice The notice of the sums to pay, accompanied by the proof of payment
In all cases	The invoices for excess fees
Spa therapy	
The original of the statement from the mandatory regime The original invoices	
The exemption from (or reimbursement of) the premium following an accident that caused hospitalisation for a duration equal to or greater than 9 consecutive nights	
In all cases	A free-form paper request for exemption A statement from the hospital showing the date of entry and date of leaving the hospital A medical certificate stating the accident with the date of the accident which resulted in hospitalisation, the background and the initial cause of the accident stating clearly "caused by a third party", if such is the case

The supporting documents cited above are to be sent to:

ASAF & AFPS - Service Prestations
Les Templiers - 950 Route des Colles - CS 50335 - 06906 BIOT-SOPHIA ANTIPOLIS CEDEX

ARTICLE 6 – PREMIUMS

6.1 - AMOUNT OF THE PREMIUMS

The amount of the premium is stated on the request for adherence. It is calculated on the basis of:
- the level of guarantee chosen,
- additional cover (if one or both additional covers have been chosen),
- the age of the Insured Person at the time of adherence,
- the place of residence,
- the family situation.

6.2 - PREMIUMS ADJUSTMENTS

The premiums change:
- on 1 January of each calendar year:
  - depending on the age of each Insured Person, as from the age of 21 years, the age calculation is made by year of birth.
  - as a result of an increase in the indexes of increases in medical services published by the Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (National Health Service for Employees) in order to take into account the change in charges and costs for health care,
  - as a result of a change in the technical results noted for a guarantees category or for a group of adherents. This change may, in particular, result in an increase of reimbursements, over the same period, which is greater than the indexes cited above.

• on 1 January of each calendar year or possibly during a year as a result of a tax, legislative or regulatory change which affects or modifies the reimbursements for social security insurance and mandatory regimes.

6.3 - TERMS FOR THE PAYMENT OF PREMIUMS

The premiums are payable in advance by complete calendar year at the registered office of the Association, in its capacity as manager, with a possibility for monthly, quarterly or half-yearly payments (the association fees of €0.30 per insured person under the age of 21 and €1,50 per insured person aged 21 and older are to be added to the monthly rate). In the event of adherence during a given period, the premium is calculated on the basis of the number of months remaining until the next payment date, including the month in progress. Any month which has commenced is payable in full. The benefit of the guarantees is subject to the payment of all of the premiums.

6.4 - CONSEQUENCES OF NON PAYMENT

In the case of a late and/or partial payment of the premium, the payments will be attributed to the oldest unpaid payment date. Taxes and charges will remain the responsibility of the Adherent. If the premium or a portion of the premium is not paid within 10 days following the due date, the Association may (independently of its right to seek performance of the contract in court):
• send a formal notice to the last known residence of the Adherent by registered letter,
• suspend the guarantee 30 days after sending this formal notice which remains without effect,
• terminate the contract and remove the Adherent 10 days after the expiration of this period of 30 days (article L. 1133 of the French Insurance Code).
The suspension or termination of the guarantee as a result of non-payment of the premium does not release the Adherent from the obligation to pay the entire premium provided for by the contract for the entire guarantee period in progress. In particular, in the case of a failure to pay a portion of the yearly premium, it is the entire amount of this premium that is owed to the Association. The Adherent shall be responsible for all costs for procedures and recovery.

6.5 - CONDITIONS FOR DEDUCTIBILITY

The premiums paid in connection with the guarantees cited in this information notice by non-salaried, non-farming workers, shall benefit from the tax provisions of the Law No. 940126 of 11 February 1994 and its application decree No. 94775 of 5 September 1994 (the Madelin Law), provided that:
• the contract is "Responsible",
• the earnings are declared in connection with a BNC or BIC status,
• the limits of tax deductibility are observed (article 154bis of the General Tax Code).
• the Self-employed Person is up to date with the payment of contributions under the mandatory health insurance and retirement regimes.

ARTICLE 7 – TERMINATION OF THE ADHERENCE

The Adherent may terminate his/her adherence to the contract and the association:
• At the time of the annual expiration: by observing advance notice of two months before the anniversary date of the contract for the first year and then, for subsequent years, advance notice of two months before the principal payment date (1 January).
• At any time following the expiration of a period of one year following the first subscription. The termination shall be effective 30 days following receipt of the notification of termination with justification.
• Following a change in situation that justifies a modification of your guarantee. The request to terminate must be addressed to us, with supporting information, within 3 months following the date of the event. This termination shall take effect one month after receipt of the notification of termination.
• In the event change in the contract, such as an increase in the premiums at the initiative of the insurer (unless this results from a legislative or regulatory change), or the scope of the commitments of the Association. The termination must be sent to us within 15 days following the date when the Adherent was informed of the change. The termination shall take effect one month after sending the notification of termination.
• In the event of the death of the Adherent (upon presentation of a death certificate). In the presence of the successors and with the consent of the Association, the rights and obligations of the deceased Adherent may be transferred to one of the successors by means of an amendment. The designation of a new Adherent must be made before the next expiration of the contract.

In all cases, the Adherent has the possibility to notify us of his/her termination:
- By simple paper or electronic letter or registered letter with proof of delivery
- By electronic means and particularly by means of his/her adherent space by connecting to asaf-afps.fr
Upon receipt of the notification, a written confirmation shall be sent to the Adherent specifying the effective date of the termination.
The Adherent only owes the portion of the premiums corresponding to the period during which the risk is covered, with this period being calculated up to the effective date of the termination. In the event that an excess has been paid, the balance shall be reimbursed within a period of thirty days following the termination date. In the event of amounts due, this must be settled according to the provisions concerning the payment of premiums provided for in the paragraph entitled "Premiums."
If the Adherent has entrusted his/her new insurer to carry out the termination formalities in order to subscribe a new contract with it, the guarantees under the contract shall be maintained, subject to payment of the premiums, until the effective date of the new insurance contract.

ARTICLE 8 – RENUNCIATION

In the case of adherence by means of solicitation: the following provisions of Article L. L112-9 of the Insurance Code shall apply:
"Any individual who is subject to solicitation at his/her domicile, residence or place of work, even at his/her request, and who signs in this connection an insurance proposal or a contract for these purposes which is not relevant to his/her commercial or professional activity has the right to waive this by registered letter or by electronic registered mail with proof of delivery during a period of fourteen calendar days following the date on which the contract was concluded, without the need to provide justification or to bear any penalty".
The Adherent may thus renounce the adherence within a period of 14 complete calendar days following the date of concluding the contract (namely, following the date on which he/she received the certificate of adherence); provided that no notification has been made of an insured event that activates the guarantee of the contract.

In the case of adherence by remote means: according to article L. 11221 of the Insurance Code, **the Adherent may waive his/her**

adherence within a period of 14 calendar days. The period commences either on the date when the Adherent received his/her certificate of adherence, or on the date when he/she received the information notice in accordance with article L.222-6 of the Consumer Code, if this date is after the date when he/she received the certificate of adherence.

In all cases, the exercise of this right to waive the adherence shall cause the termination of the adherence, and terminate all of the guarantees as from the date of receiving the letter of waiver, provided that no service has already been paid in connection with this contract. The premiums already paid shall be reimbursed pro rata for the guarantee period already accrued, within a period of 30 days following the date of receiving the letter of waiver.
In order to waive the adherence, the Adherent must send notice of his/her desire by registered letter with proof of delivery to: ASAF & AFPS - Les Templiers - 950 Route des Colles - CS 50335 - 06906 BIOT - SOPHIA ANTIPOLIS CEDEX before the expiration of the period of 14 days indicated above.
It may be prepared according to the model letter included below:

"I, the undersigned, (full name, address), declare that I renounce my adherence to British Health Ways 4 No..... concluded with the firm ....., dated ...../...../..... and for which I have paid €.....
Executed at ....., on ...../...../..... Signature of the Adherent."

ARTICLE 9 – COMPLAINTS

For any difficulties, contact your ASAF & AFPS contact person by e-mail at contact@gieps.fr or by letter (ASAF & AFPS - Les Templiers - 950 Route des Colles - CS 50335 - 06906 BIOT-SOPHIA ANTIPOLIS CEDEX). Your contact person is at your disposal to respond to your requests for information.
If a misunderstanding continues after having made contact, you may appeal to the Client Satisfaction Service of ASAF & AFPS by e-mail (service.satisfaction@gieps.fr) or by letter (Les Templiers - 950 Route des Colles - CS 50335 - 06906 BIOT-SOPHIA ANTIPOLIS CEDEX). The Client Satisfaction Service is authorised to handle your claims within a maximum period of 60 days, after sending acknowledgement of receipt within 10 days. If no solution is found, you may appeal free of charge to the Mediator for the FFA, an independent entity, within a maximum period of one year following your written complaint, by addressing: La Médiation de l'Assurance (the Insurance Mediation) - TSA 50110 - 75441 PARIS CEDEX 09 or on the internet site www.mediation-assurance.org. The Mediator will provide an opinion within 3 months after receiving the complete application. The Mediator's opinion is not mandatory and will allow you to bring the matter before the appropriate court.

ARTICLE 10 - MISCELLANEOUS PROVISIONS

10.1 - TELEPHONE SOLICITATION

If you are a consumer and you do not wish to be commercially solicited by telephone, you may register free of charge on the list for blocking telephone solicitation, BLOCTEL. For more information, consult the site www.bloctel.gouv.fr.

10.2 - EXPERT REPORTS AND SUPPORTING DOCUMENTS

The Association may, at its request and for the use of its Advising Physician, have carried out any verifications or expert proceedings that it considers necessary as well as to have transmitted to it the documents and reports, whether medical or not, which are necessary to process the dossier.

10.3 - SUBROGATION

In the event of an accident caused by a third party, the declaration must be sent directly to the Association. After the reimbursement of medical costs in accordance with the conditions set out in the table of services, the Insurer will recover the payments made to the Insured Party by taking action against the third party responsible for the accident in accordance with article L. 12112 of the Insurance Code.

10.4 - LEGISLATIVE AND REGULATORY CHANGES

When law or regulations change the contractual conditions or the scope of its commitments, the Association may need to change the terms of your adherence in order to adapt to the new situation as from the application of these new regulations or, at the latest, as of the next renewal that follows the application of these regulations.

10.5 - COMBATING MONEY LAUNDERING AND THE FINANCING OF TERRORISM

In our capacity as an insurance intermediary, we are subject to the legal obligations concerning anti-money laundering and countering the financing of terrorism resulting principally from the Monetary and Financial Code (Articles L.561-1 et seq. of the Monetary and Financial Code).
In order to allow us to comply with these obligations, you undertake to provide to us the information and supporting documents for identification and knowledge of you as the Adherent as well as those concerning the insured parties and the beneficiaries, as the case may be. On the basis of the principle of ongoing vigilance, all of this information must be updated, particularly at the time of providing the services in favour of the insured parties and/or beneficiaries.
You also undertake that the sums that are or will be paid by you in connection with this contract do not derive from tax fraud or any other infraction punishable by imprisonment for more than one year and that these funds do not participate in the financing of terrorism.
In the event of not complying with these various obligations and in the cases legally provided for, the Insurer shall make a declaration of suspicion with TRACFIN or any other formality with the competent authorities in accordance with the regulations cited above.

10.6 - RESTRICTIVE MEASURES

This contract shall be without effect and the Insurer will not be required to pay compensation or provide guarantees in this connection when the performance of the contract may expose the Insurer to sanctions, prohibitions or restrictions resulting from resolutions of the United Nations or economic or commercial sanctions provided for by the laws or regulations enacted by the European Union, the United Kingdom or the United States of America.

10.7 - TIME LIMITATIONS

In accordance with article L. 1141 of the Insurance Code, "All actions deriving from an insurance contract are subject to time limitations of two years following the date of the event in question. By exception, actions arising from an insurance contract relating to damage resulting from ground movements due to drought and soil dehydration, recognised as a natural disaster under the conditions set out in Article L. 125-1, shall be barred after five years have elapsed following the event giving rise to them.

However this period is only valid:
1° In the event of withholding information, omissions, false or incorrect declarations concerning the risk incurred, as from the date when the insurer became aware thereof.
2° In the event of an insured event, as from the date when the interested parties became aware thereof, if it is proven that they were unaware before then.

When the insured party's action against the insurer concerns a claim by a third party, the period for the time limit only begins running on the date when this third party brought a court action against the insured party or when the third party was compensated by the insured party.
The time limitation is increased to ten years for life insurance contracts when the beneficiary is a different person from the subscriber and, in insurance contracts covering accidents affecting persons, when the beneficiaries are the heirs of the deceased insured person.
For life insurance contracts, notwithstanding the provisions in paragraph 2, the actions of the beneficiary are time barred at the latest thirty years following the death of the insured party."
In accordance with article L. 1142 of the Insurance Code, "*The time limitation is suspended by any of the standard causes for suspension of time limitations and by the appointment of experts following an insured event. The suspension of the time limitation may, moreover, be the result of the insurer sending a registered letter or electronic registered mail with proof of delivery to the insured party concerning the payment of the premium and by the insured party sending a registered letter with proof of delivery to the insurer concerning the payment of the compensation*."

The ordinary clauses for the interruption of the time limitations to which Article L. 1142 of the Insurance Code refers are:
- *The debtor's recognition of the right of the party subject to time limitations which interrupts the period of the time limitation (article 2240 of the Civil Code).*
- *The court motion, even in summary proceedings, which interrupts the period of time limitation as well as the period for the end of the time limitation. This applies even when it is brought before a court which lacks jurisdiction or when the motion to bring the matter before the court is cancelled for procedural reasons (article 2241 of the Civil Code).*
- *The interruption resulting from the court motion produces its effect until the conclusion of the case (article 2242 of the Civil Code).*
- *The interruption is without effect if the plaintiff withdraws its request or allows the case to expire, or if its request is definitively rejected (article 2243 of the Civil Code).*
- *The period for time limitation or the period for expiration is also interrupted by a protective measure adopted in application of the Code of Civil Procedures of Execution or an act for forced execution (article 2244 of the Civil Code).*
- *The interpellation made against one of the joint debtors by a court motion or by an act for forced execution or the recognition by the debtor of the right of the time limited party which interrupts the period for time limitation against all other parties, even against their heirs. On the other hand, the interpellation made against one of the heirs of a joint debtor or the recognition of this heir does not interrupt the period for time limitation with regard to the other heirs, even in the case of a mortgage debt, if the obligation is divisible. This interpellation or this recognition only interrupts the period for time limitation with regard to the other co-debtors to the extent that this heir is committed. In order to interrupt the period for time limitation for the entirety, with regard to the other co-debtors, the interpellation must be made to all of the heirs of the debtor or the recognition of all of these heirs (article 2245 of the Civil Code).*
- *The interpellation made to the principal debtor or the debtor's recognition interrupts the period for time limitation against the guarantee (article 2246 of the Civil Code).*

In accordance with article L. 1143 of the Insurance Code, "*the parties to an insurance contract may not, even by mutual agreement, modify the duration of the time limitation or add clauses which suspend or interrupt the time limitation*."

BRITISH HEALTH WAYS 4

ASSISTANCE GUARANTEE

INTRODUCTION

This information notice cites the general conditions for assistance agreements bearing the number 0803819 and subscribed by the Association ASAF (Association Santé et Action Familiale) and the number 0803818 subscribed by the Association AFPS (Action Familiale de Prévoyance Sociale) for their adherents with INTER PARTNER ASSISTANCE (AXA Assistance) a limited liability company organised under Belgian law with a share capital of 31,702,613 euros, a non-life insurance company approved by the National Bank of Belgium (0487), registered with the Registry of Legal Entities of Brussels under the number 415 591 055, with its registered office located at 166 Avenue Louise – 1050 Ixelles – Brussels – Belgium, in the person of its French branch registered with the Registry of Trade and Companies of Nanterre under the number 316 139 500 and located at 6 rue André Gide 92320 Châtillon (France). IPA acts under the trademark of Axa Assistance.
It has the objective of providing assistance guarantees to the adherents and the insured members of their families appearing on the certificate of adherence.

ARTICLE 1 – WHAT DOES THE BENEFICIARY NEED TO DO IN THE CASE OF AN INSURED EVENT?

FOR THE ASSISTANCE GUARANTEES: In order to benefit from the guarantees under this Contract, you must call the following telephone number:

+33 (0)1 55 92 25 99

(this is a toll-free number, the cost of the call is borne by the Beneficiary).
Our medical team decides, on the basis of the mandatory medical and technical thresholds, the necessity and the terms for our intervention.
However, and for each decision concerning you, your consent or the consent of a member of your family is necessary in advance. You may accept or refuse the recommendations that we make, but if you reject them, your assistance guarantees are immediately cancelled.
If the Beneficiary his/her family organise all or part of the guarantees provided for by the Contract without the prior consent of AXA Partners and acknowledged by a file number, these costs may not result in a reimbursement.
Only services organised by or in accordance with AXA Partners are covered or reimbursed, provided that the original supporting documents and the corresponding file number are provided.
AXA Partners intervenes in accordance with national and international laws and regulations

Send the original supporting documents and corresponding file number to:

AXA Assistance
Service Gestion des Règlements (Payment Management Service)
6, rue André Gide
92320 Châtillon (France)

ARTICLE 2 – DEFINITIONS

In this information notice, the words or expressions starting with a capital letter shall have the following meanings:

ACCIDENT: A sudden change in the health of the beneficiary which is caused by a sudden, unpredictable and violent external event that is independent of the will of the victim.

ADHERENT: The Adherent is the insured party who adheres to the association ASAF & AFPS and who is covered by a British Health Ways 4 insurance contract.

ASSISTING PERSON: For this Contract the Assisting Person is the insured party who assists his/her dependent father, mother, son, daughter or spouse.

DOMESTIC ANIMALS: Designates the dog and/or cat belonging to the Insured Party and which normally lives at his/her Domicile, to the exclusion of any other species of animal, provided that the animal's vaccinations are up to date in accordance with French legislation, subject to the provisions of the Law No. 99-5 of 6 January 1999 concerning dangerous and stray animals and the protection of animals. Domestic animals trained for attack are excluded.

SERIOUS BODILY HARM: An accident to the body or an unforeseeable illness which, in a short time, risks causing a significant aggravation of the condition of the beneficiary if appropriate care is not provided rapidly.

MEDICAL AUTHORITY: Any person who holds of a valid diploma in medicine or surgery in the country where the beneficiary is located.

BENEFICIARIES: The adherent of the Association who is a head of family and who subscribes to the health insurance contract, and his/her legal or de facto spouse or any person connected with the beneficiary by a civil union (a PACS). Their unmarried children up to the ages of 25 years living at the domicile of the subscriber and who are tax dependent. Their ascendants living at the domicile of the subscriber. Grandchildren under the age of 15 years.
The beneficiaries are guaranteed when they are designated on the health certificate of adherence delivered by the Association.

DOMICILE: The principal and usual place of residence of the beneficiary as stated on his/her income tax declaration or any other official document. This is necessarily located in France.

MEDICAL TEAM: A structure adapted to each particular case and defined by our regulating doctor.

HOSPITALISATION: A planned (scheduled less than 5 days before the start of hospitalisation) or unplanned stay in a public or private establishment which is prescribed for medical or surgical treatment following serious bodily harm.

IMMOBILISATION AT THE DOMICILE: The obligation to remain at the domicile as the result of serious bodily harm and upon the instructions of a physician.

ILLNESS: Sudden and unexpected changes in the health of the beneficiary as witnessed by a competent medical authority.

NEXT OF KIN: Any person designated by the beneficiary or any of his/her successors and who are domiciled in the same country as the beneficiary.

ARTICLE 3 – WHERE IS THE BENEFICIARY GUARANTEED?

The guarantees are performed in France, Andorra, Monaco and the French overseas territories, regions and departments. The guarantees for "Medical Repatriation" and the return of the insured persons are performed Worldwide.

ARTICLE 4 – ASSISTANCE GUARANTEES

4.1 - CUSTODY OF CHILDREN: In the event of the Hospitalisation of the beneficiary for more than 5 days and if no one can provide custody for the beneficiary children or grandchildren under the age of 15, AXA Assistance shall organise and cover, as from the first day of the incident:
• either transportation of the children or the grandchildren to the domicile of a close relative,
• or transportation of a close relative to the domicile of the beneficiary,
• or the custody of the children or grandchildren by qualified persons within the limit of 40 hours in the 5 days following the hospitalisation of the Insured Person, with a minimum of 2 consecutive hours.
This person, depending on the age of the children, will also ensure they are accompanied to school. In no event shall this custody exceed the duration of the hospitalisation or immobilisation.
AXA Assistance shall take responsibility for the round trip air transport in economy class or by train in 1st class and, depending on the circumstances, the costs of accompanying the children to a close relative by qualified personnel.
AXA Assistance only acts at the request of the parents and cannot be held responsible for events that may occur during the travel or during the custody of the children. This guarantee is limited to one intervention per calendar year.
Beyond that one intervention per calendar year, AXA Assistance can communicate the coordinates of qualified personnel to the beneficiary. The cost of the qualified personnel remains the responsibility of the beneficiary.

4.2 – CUSTODY OF SICK CHILDREN: When the treating physician considers that the state of health of a beneficiary child under the age of 15 years requires medically prescribed immobilisation for greater than 8 consecutive days and when no one can ensure the child's custody, as from the first day of the incident, AXA Assistance shall organise and cover:
• either the transportation of a close relative to the domicile of the beneficiary by providing round-trip air travel in economy class or by train in 1st class,
• or the custody of the children by qualified personnel at the domicile of the beneficiary for a maximum of 40 hours over the 10 days following the event with a minimum of 2 consecutive hours. AXA Assistance only acts at the request of the parents and cannot be held responsible for events that may occur during the travel or during the custody of the children. This guarantee is limited to one intervention per calendar year.

Beyond that one intervention per calendar year, AXA Assistance can communicate the coordinates of qualified personnel to the beneficiary. The cost of the qualified personnel remains the responsibility of the beneficiary.

4.3 - SCHOOLING ASSISTANCE OF CHILDREN: When the treating physician considers that the health of the beneficiary child requires immobilisation at the domicile and this obligation causes absence from school for more than 15 consecutive days, AXA Assistance shall find and take responsibility for one or more tutors. The support is intended for children who are schooled in FRANCE, in a French educational establishment for classes from last level primary to completion.
The tutor(s) shall provide courses for the child in the principal subjects: French, maths, history, geography, physics, biology, foreign languages.
The fees for the tutor(s) are covered for all of the subjects up to a maximum of 5 hours per week for primary education and 10 hours per week for secondary schooling.
These courses are provided as from the 16th day of the child's immobilisation at the domicile for a maximum of 2 months, excluding holidays and school vacations.
This guarantee is limited to one intervention per calendar year. Beyond that one intervention per calendar year, AXA Assistance can communicate the coordinates of qualified personnel to the beneficiary. **The cost of the qualified personnel remains the responsibility of the beneficiary.**

4.4 - HOME HELP: At the request of the beneficiary, AXA Assistance shall find and take responsibility for the services of a home helper at the domicile either during the period of Hospitalisation or immobilisation of more than 24 hours, or upon his/her return to the domicile. It shall also take responsibility for the performance of daily tasks. AXA Assistance shall take responsibility for a maximum of 30 hours during the 15 days following the date of the event, with a minimum of 2 consecutive hours. The beneficiary must make his/her request within 8 days following the date of the event. The medical team of the assistance service is solely authorised to set the duration of presence of the home helper after a medical assessment. **This guarantee is limited to one intervention per calendar year.** Beyond that one intervention per calendar year, AXA Assistance can communicate the coordinates of qualified personnel to the beneficiary. The cost of the qualified personnel remains the responsibility of the beneficiary.

ARTICLE 5 - ASSISTANCE TO DOMESTIC ANIMALS GUARANTEE

5.1 - CUSTODY AND TRANSFER OF DOMESTIC ANIMALS (DOGS AND CATS ONLY): In the event of Hospitalisation for more than 8 days and if the domestic animals cannot benefit from their usual custody, AXA Assistance shall organise and take responsibility, within a radius of 50 km, from the domicile of the beneficiary:
• either for the transfer and the custody of the animals (maximum 2) to the shelter closest to the domicile. The costs for the shelter are covered up to €229 per event and for all of the animals.
• or the transfer of the animals (maximum 2) to the domicile of a friend or relative.

5.2 - EXCLUSIONS SPECIFIC TO THE GUARANTEE OF ASSISTANCE TO DOMESTIC ANIMALS: No guarantee of assistance may be provided if the beneficiary is not able to present the health and vaccinations book for the animal subject to the guarantee, and which is up-to-date in accordance with the regulations in force.

The following are excluded and may not result in intervention by AXA Partners, or be subject to any indemnification whatsoever:
- **illnesses prior to subscribing the contract,**
- **illnesses that could have been prevented by vaccinations,**
- **anomalies, infirmities or congenital illnesses,**
- **illnesses not connected with a surgical intervention (for example, flu, etc.),**
- **any intervention that is not performed by a veterinarian,**
- **interventions for aesthetic purposes (ear cropping or tail docking, etc.) and for convenience (castration, spaying, abortion, etc.),**
- **dental prostheses as well as any devices,**
- **births or caesarean procedures that are not caused by an accident,**
- **vaccinations, boosters and tattooing,**
- **wounds resulting from organised dog fights,**
- **poor treatment which is the responsibility of the owner or persons living under his/her roof, or the custodian of the animal,**
- **veterinary costs not provided for by the agreement,**
- **costs resulting from a dead animal,**
- **costs of cremation.**

ARTICLE 6 – EXCLUSIONS COMMON TO ALL THE GUARANTEES

The following are excluded and may not result in intervention, or be subject to any indemnification whatsoever:
- **Any interventions and/or reimbursements relating to medical assessments, check-ups, screening, for preventative purposes, regular treatments or analyses and, in general, any intervention or care which has a repetitive or regular character;**
- **Voluntary terminations of pregnancy;**
- **Convalescence, illnesses undergoing treatment that have not yet been consolidated and/or which require later programmed care;**
- **Pre-existing illnesses or injuries that were diagnosed and/or treated and which were subject to medical consultation or Hospitalisation during the six (6) months prior to the date for assistance;**
- **Suicide attempts and their consequences;**
- **Rejuvenation cures, weight-loss cures or any cosmetic treatments;**
- **Medical costs, treatments and stays in rest homes and the costs of rehabilitation;**
- **Incidental costs such as meals and beverages that the Insured Party would normally have borne during his/her Travel;**
- **The costs for transport and lodging initially planned for the Travel of the Insured Party;**
- **The cost of telephone communications, except for those made in connection with putting in place the assistance guarantees for this contract.**

In addition, the following are excluded and may not result in intervention, or be subject to any indemnification whatsoever regardless of the consequences:
- **The abuse of alcohol (a blood alcohol rate found to be greater than the rate set by the regulations in force), the use or taking of medications, drugs or narcotics that are not prescribed medically;**
- **An intentional act or misconduct on the part of the Insured Party;**
- **The costs for search and rescue resulting from a failure to observe the rules for caution set by the operators of the site and/or the regulatory provisions governing the activity that you practice;**
- **Damages that the Insured Party has caused or suffered when engaging in the following sports: bobsledding, mountain climbing, or rock climbing;**
- **The Insured Party's participation as a competitor in any sporting competition or endurance or speed competitions and their preparatory trials, on board any land or air machinery (whether motorised or not), as well as the practice of snow and ice sports in the capacity of a non-amateur;**
- **the failure to observe the recognised safety rules connected with the practice of any sporting or leisure activity;**
- **The explosion of machinery and nuclear radioactive effects;**

ARTICLE 7 – RESPONSIBILITY

7.1 - RESPONSIBILITY OF AXA ASSISTANCE The commitment of AXA Assistance is based on an obligation of means. AXA Assistance undertakes to mobilise all of the means of action that it possesses in order to perform all of the assistance services provided for above.

AXA Assistance may not be held liable for any damages of a professional or commercial character suffered by a Beneficiary as the result of an event which requires the intervention of the assistance services.
AXA Assistance may not be substituted for the local or national emergency search and rescue organisations and shall not take responsibility for costs incurred as a result of their intervention, unless contractually stipulated to the contrary.

7.2 - EXONERATION FROM RESPONSIBILITIES Nonetheless, AXA Assistance may not be responsible for the non-performance or delays in performing the services that are caused by a case of force majeure which makes it impossible to perform the contractual commitments.

ARTICLE 8 – SUBROGATION IN THE RIGHTS AND ACTIONS OF THE INSURED PARTY

AXA Assistance is subrogated in the rights and actions of the beneficiary against any third party responsible for the event that caused its intervention and/or indemnification, up to the total of the costs incurred and/or the indemnities paid in performance of the Contract.

ARTICLE 9 – EFFECTIVE DATE - DURATION - TERMINATION

The assistance guarantees are acquired by the Insured Parties throughout the duration of the BRITISH HEALTH WAYS 4 insurance contract.
They shall automatically cease to have effect, without other notification, on the date when the BRITISH HEALTH WAYS 4 insurance contract terminates for any reason whatsoever.

ARTICLE 10 – PROTECTION OF PERSONAL DATA

In its capacity as data controller, the information concerning the Insured Persons is collected, used, and stored by AXA Assistance for the subscription, conclusion, management, and performance of this Contract, in accordance with the provisions of the applicable regulations in terms of the protection of personal data and in accordance with its policy for the protection of personal data, as published on its internet site.

Thus, in the context of its activities, AXA Assistance may:
(a) Use the information of the Insured Person or the information of the persons benefiting from the guarantees in order to provide the services described in this Notice. By using the services of AXA Assistance, the Insured Person consents to AXA Assistance using his/her data for these purposes;
(b) To transmit the personal data of the Insured Person and the data relating to his/her Contract to the entities of the AXA Group, to the service providers of AXA Assistance, to the personnel of AXA Assistance, and to any persons who may intervene within the limits of their respective attributes in order to manage the Insured Person's file of insured events, to provide to him/her the guarantees due to him/her under the Contract, to undertake payments and to transmit these data if the law requires or permits this;
(c) To listen to and/or record telephone calls with the Insured Person in connection with improving and monitoring the quality of the services rendered;
(d) To carry out statistical and actuarial studies as well as client satisfaction analyses in order to better adapt our products to the market requirements;
(e) To obtain and retain any relevant and appropriate photographic document of the Client's asset, in order to provide the services offered in connection with his/her assistance contract and to validate his/her request;
(f) To send quality inquiries (in the form of requests to return forms or by surveys) relating to the services of AXA Assistance and other communications relating to client service; and
(g) To use the personal data in connection with combating fraud. If necessary, this processing may lead to registration on a list of persons who present a risk of fraud.
AXA Assistance is subject to legal obligations resulting in particular from the Monetary and Financial Code in terms of combating money laundering and countering the financing of terrorism and, in this connection, AXA Assistance implements a procedure to supervise the contracts, which may result in the submission of a declaration of suspicion in accordance with the provisions of the law in this matter.

The data collected may be communicated to other companies of the AXA Group or to a third party partner, including for use for commercial prospecting. If the Insured Person does not want his/her data to be transmitted to the companies of the AXA Group or to a third party for use for prospecting purposes, he/she may object to this by writing to:

Délégué à la Protection des données (*Data Protection Officer*)
AXA Assistance
6, rue André Gide 92320 Châtillon (France)
E-mail: dpo.axaAssistancefrance@axa-assistance.com

For any use of the personal data of the Insured Person for other purposes or when the law requires this, AXA Assistance must seek his/her consent.
The Insured Person may withdraw his/her consent at any time.
By subscribing this contract and by using its services, the Insured Person acknowledges that AXA Assistance may use his/her personal data and consents to AXA Assistance using the sensitive data described above. If the Insured Person provides to AXA Assistance information concerning third parties, the Insured Person undertakes to inform such third parties of the use of their data, as defined above, as well as in accordance with the confidentiality policy of the internet site of AXA Assistance (see below).
The Insured Person may, upon simple request, obtain a copy of the information concerning him/her. The Insured Person possesses a right to be informed concerning the use made of his/her data (as indicated in the confidentiality policy of the AXA Assistance site - see below) and a right to rectification if he/she notes an error.
If the Insured Person wishes to know the information held by AXA Assistance concerning him/her, or if he/she has other requests concerning the use of his/her data, he/she may write to the following address:

Délégué à la Protection des données (*Data Protection Officer*)
AXA Assistance
6, rue André Gide 92320 Châtillon (France)
E-mail: dpo.axaAssistancefrance@axa-assistance.com

Our entire confidentiality policy is available on the site: axa-assistance.fr or in paper format, upon request.

ARTICLE 11 – CLAIMS AND MEDIATION

In the event of a disagreement concerning the management of the contract, the Subscriber and/or the Insured Persons must first contact their preferred contact person in order to find solutions that are appropriate for the difficulties encountered.
If the response given is not satisfactory, the Subscriber and/or the Insured Persons may address their claim by post to the following address:

AXA Assistance - Service Gestion Relation Clientèle
6, rue André Gide
92320 Châtillon (France)

Or on the internet site under the heading "contact" www.axa-assistance.fr/contact.

AXA Assistance undertakes to acknowledge receipt within ten (10) working days following receipt of the claim, unless a response is provided within this period.
A response will be sent within a maximum period of two (2) months, unless the complexity requires an additional period.
After the means of internal recourse listed above are exhausted and if a disagreement continues, the Subscriber and/or the Insured Persons may call on a Mediator, an independent entity, within the maximum period of one year following the written claim by writing to the following address:

La Médiation de l'Assurance
TSA 50110
75441 Paris Cedex 09

Or by completing the form for mediation directly on the internet site: www.mediation-assurance.org

This examination is free of charge. The opinion of the Mediator is not mandatory and the Insured Party is free to bring the matter before a competent French court.
The Mediator will issue an opinion within a period of ninety (90)

days following receipt of the complete application.
The Charter on "Insurance Mediation" may also be consulted at the following link:
www.mediation-assurance.org/medias/mediation-assurance/Charte_V2.pdf

ARTICLE 12 – TIME LIMITATIONS

In accordance with Article L 114-1 of the Insurance Code, any actions deriving from this contract are limited in time for two (2) years following the event which gave rise to such action.
This period is only valid:

- in the case of withholding or omission of information, false or inaccurate declaration concerning the risk incurred as of the date when the insurer learns of this;
- in the event of an insured event, as of the date when the interested parties became aware of this, if they can prove that they were unaware before then.

When the Insured Party's action against the insurer concerns a claim by a third party, the period for the time limit only begins running on the date when this third party brought a court action against the insured party or when the third party was compensated by the insured party.

The time limitation is increased to ten (10) years in insurance contracts covering accidents harming persons when the beneficiaries are the successors of the deceased insured party.
In accordance with Article L114-2 of the Insurance Code, the time limitation is interrupted by ordinary causes that interrupt the time limitation, such as:

- any court request, even in summary proceedings, or even if brought before a court that does not have jurisdiction;
- any act of forced execution, or any conservatory measure made in application of the Code of Civil Procedure of Execution;
- any acknowledgement by the insurer of the insured party's right to guarantee, any acknowledgement of the insured party's debt to the insurer.

The time limitation is also interrupted by:

- the appointment of experts as a result of an insured event;
- sending of a registered letter with proof of delivery sent by the insurer to the insured party concerning an action for payment of the subscription or by the insured party to the insurer concerning payment of compensation.

In accordance with Article L114-3 of the Insurance Code, the parties to the insurance contract may not, even by joint agreement, modify the duration of the time limitation or add clauses that suspend or interrupt this.

ARTICLE 13 – SUPERVISORY AUTHORITY

Inter Partner Assistance (AXA Assistance) is subject, in its capacity as an insurance company under Belgian law, to the prudential control of the Belgian National Bank located at Boulevard de Berlaimont 14 – 1000 Brussels – Belgium - VAT BE 0203.201.340 RPM Brussels (www.bnb.be). The French branch of IPA is subject to the prudential control of the Autorité de Contrôle Prudentiel et de Résolution (ACPR), located at 4 place de Budapest CS 92459 - 75346 PARIS Cedex 09.

ARTICLE 14 - COURT JURISDICTION

Any dispute that arises from the performance, failure to perform or the interpretation of the Contract shall be subject to the jurisdiction of French courts.

For more information:

asaf-afps.fr

For all correspondence:

ASAF & AFPS

Les Templiers - 950 route des Colles - CS 50335

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